Fecal Occult Blood Test Kit

Colon Health Screening Exams

Colonoscopy

Nebraska Colon Cancer Screening Program

CLIENT INFORMATION BOOKLET

In this booklet you will find information on how Nebraska Colon Cancer Screening Program can serve you.

Nebraska Health and Human Services
Nebraska Colon Cancer Screening Program
301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817

Toll Free: 1-800-532-2227

Fax: 471-0913

E-mail: ncp@hhss.ne.gov

Website: www.hhss.ne.gov/crc

Version June 2006

What is the Nebraska Colon Cancer Screening Program (NCP)?

NCP is the newest program added to Every Woman Matters (EWM). Nebraska is one of only five such programs in the nation. The goal of NCP is to increase screening for colon cancer and to decrease the number of Nebraskan's who are diagnosed and die from colon cancer.

This program is what we call a Demonstration Program! This means that research is being done to see if this type of program works. In order to carry out the program there are strict eligibility guidelines based on personal and family history. Not everyone who completes an enrollment form will be eligible.

As a client of NCP, you have access to quality health care services, education, and information to help you make healthy lifestyle choices for personal wellness.

NCP offers the following tests if you meet the strict eligibility guidelines:

- Fecal Occult Blood Test
- Colonoscopy

Anyone over the age of 50 is eligible to complete an enrollment form. To find out if you are eligible for the program, you must:

- Fill out a Colorectal Health History form; and
- Sign a Release of Medical Information.

A man or woman may be eligible for the NCP if:

- He / She is 50 years of age and older;
- He / She does not belong to an HMO (Health Maintenance Organization);
- He / She does not belong to Medicaid;
- He / She does not belong to Medicare; and
- He / She is within the income guidelines (the income guidelines change every year in July).

For questions regarding the NCP, call **1-800-532-2227** Monday through Friday from 8:00 a.m. to 5:00 p.m. (Central Standard Time) or you can e-mail us at ncp@hhss.ne.gov.

Once you enroll in the program, you are enrolled for the life of the program.

Enclosed in this packet you have received:

- Booklet
  - Steps to Take on How to Use the Program
  - Notice of Information Privacy Practices
  - Colon Cancer Screening Guidelines
  - Colon Cancer Terms and Definitions
  - Informed Consent and Release of Medical Information (for you to keep)
  - Enrollment Form for a current EWM client (women 50+ only)
  - Enrollment Form for any person who is 50+ and meets program eligibility guidelines
- Postage Paid Envelope

What Steps Do I Take?

If you're already an Every Woman Matters (EWM) Client:

1. ☐ Read, complete, and sign the Colon Health History and Release of Medical Information located on pages 9 and 10 of this packet.

2. ☐ Mail the following information in the postage-paid envelope:
   - ☐ Your completed Colon Health History and signed Release of Medical Information.

If you are not an Every Woman Matters (EWM) Client:

1. ☐ Read, complete, and sign the Enrollment Form, Colon Health History and Release of Medical Information located on pages 11 and 12 of this packet.

2. ☐ Mail the following information in the postage-paid envelope:

   - ☐ Your completed Enrollment Form, Colon Health History and signed Release of Medical Information.

The Nebraska Colon Cancer Screening Program will use your Colon Health History to determine your eligibility to participate. The NCP has strict eligibility guidelines.

Once the program has determined your eligibility, you will receive information by mail.

If you need more enrollment forms for others in your home or friends or family that are over 50 or if you have any questions please call us at **1-800-532-2227** or you can e-mail us at ncp@hhss.ne.gov.

Colon Cancer Terms and Definitions

Anus - The opening of the rectum to the outside of the body.

Cancer - A disease in which cells grow out of control. Cancer cells can invade nearby tissue and spread to other parts of the body.

Colon - The long, coiled, tube-like organ (also known as large bowel or large intestine) that removes water from digested food. The remaining material, solid waste called "stool," moves through the colon and the rectum and leaves the body through the anus. Parts of the colon include: cecum, ascending colon, transverse colon, descending colon, and sigmoid colon. The average colon is approximately 6 feet long.

Colonoscope - A flexible, lighted instrument with a built-in tiny camera used to view the inside of the entire colon and rectum.

Colonoscopy - Before this test, you will take a strong laxative to clean out the colon. Colonoscopy is conducted in a doctor's office, clinic, or hospital. You are given a sedative to make you more comfortable, while the doctor uses a narrow, flexible, lighted tube to look inside the rectum and the entire colon. During the exam, the doctor may remove some polyps and collect samples of tissue or cells for more testing. This test is recommended every 10 years.

Colorectal - Related to the colon, rectum, or both.

Crohn's Disease - Crohn's disease is an ongoing disorder that causes inflammation of the digestive tract, also referred to as the gastrointestinal (GI) tract.

Double-Contrast Barium Enema- This test is conducted in a radiology center or hospital. Before the test, you use a strong laxative and/or enema to clean out the colon. This procedure involves taking x-rays of the rectum and colon after you are given an enema with a barium solution, followed by an injection of air. The barium coats the lining of the intestines so that polyps and other abnormalities are visible on the x-ray. This test is recommended every 5 years.

Familial Adenomatous Polyposis (FAP) - **Familial** means that it runs in families. Each child of an affected parent has a 50% risk of inheriting the disease gene. **Adenomatous** is a type of mushroom-shaped growth or polyp, which may be precancerous. **Polyposis** is a condition where 100 or more polyps can form in the large intestines.

Fecal Occult Blood Test (FOBT) – A test that checks for hidden blood in the stool. At home, using a small stick from a test kit, you place a small amount of your stool, from three different bowel movements three days in a row, on test cards. You return the cards to your doctor's office or a lab, where they're checked for blood. This test is recommended yearly. If blood is found, you will need a follow-up colonoscopy.

First (1st) Degree relative - Parents, brothers, sisters, or children

Flexible Sigmoidoscopy – Before this test, you use a strong laxative and/or enema to clean out the colon. Flexible sigmoidoscopy is conducted at the doctor's office, clinic, or hospital. The doctor uses a narrow, flexible, lighted tube to look at the inside of the rectum and the lower portion of the colon. During the exam, the doctor may remove some polyps (abnormal growths) and collect samples of tissue or cells for more testing. This test is recommended every 5 years. If polyps are found, you will need a follow-up colonoscopy.

Gastroenterologist - A doctor who specializes in diagnosing and treating disorders of the digestive system (which includes the esophagus, stomach, pancreas, intestines, and liver).

Colon Cancer Terms and Definitions

Gastrointestinal Tract - The part of the digestive tract where the body processes food and eliminates waste. It includes the esophagus, stomach, liver, intestines, and rectum.

Hereditary Non Polyposis Colorectal Cancer (HNPCC) - Also known as the Lynch syndrome, is an inherited cause of cancer of the bowel.

Inflammatory Bowel Disease (IBD) - Inflammatory bowel disease is the name of a group of disorders that cause the intestines to become inflamed (red and swollen).

Intestine - The long, tube-shaped organ in the abdomen, also called the "bowel", that completes the process of digestion. There are both a large and small intestine.

Polyp - An abnormal, often precancerous growth of tissue (colorectal polyps are growths of tissue inside the intestine).

Rectum - The last 8 to 10 inches of the large intestine. The rectum stores solid waste until it leaves the body through the anus.

Screening Test - "Screening tests" are tests used to check, or screen, for disease when there are no symptoms. Screening tests for colorectal cancer include: fecal occult blood test, flexible sigmoidoscopy, colonoscopy, and double contrast barium enema. (When a test is performed to find out why symptoms exist, it is called a "diagnostic" test).

Sigmoidoscope - A flexible, lighted instrument with a built-in tiny camera that allows the doctor to view the lining of the rectum and lower portion of the colon.

Stool - The waste matter discharged in a bowel movement; feces.

Stool Test - A test to check for hidden blood in the bowel movement (also see Fecal Occult Blood Test).

Sources for definitions: National Cancer Institute and Centers for Disease Control and Prevention.

Notice of Information Privacy Practices

PLEASE FILE FOR FUTURE REFERENCE. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective: 04/14/2003

The Health and Human Services System of the State of Nebraska, and those Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Nebraska Partnership for Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information.

PRACTICES AND USES:
HHSS may access, use and share medical information for purposes of :

- **Treatment:** We may use your medical information to provide you with medical treatment or services. For Example; a doctor may need to tell the dietitian if you have diabetes so that appropriate meals can be prepared.
- **Payment:** We may use and disclose your medical information so that the treatment and services you receive can be billed. For example, we may use your medical information from a surgery you received at the hospital so that the hospital can be reimbursed.
- **Operations:** We may use and disclose medical information about you for medical operations. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff.

OTHER PERMITTED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT:

- **Required By Law:** We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. You will be notified, if required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **Communicable Diseases:** We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose Protected Health Information to a health oversight agency for activities authorized by law, or other activities necessary for appropriate oversight of the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- **Abuse or Neglect:** We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. The disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Food and Drug Administration:** We may disclose your Protected Health Information to a person or company as required by the Food and Drug Administration.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determinations, or for the coroner or medical examiner to perform other duties authorized by law.
- **Research:** We may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board to ensure the privacy of your Protected Health Information.
- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel.
- **Workers' Compensation:** We may disclose your Protected Health Information as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Inmates:** We may use or disclose your Protected Health Information if you are an inmate of a correctional facility in the course of providing care to you.
- **Required Uses and Disclosures:** Under the law, we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR, Title II, Section 164, et. seq.

Notice of Information Privacy Practices

(Continued)

OTHER USES OF MEDICAL INFORMATION
You can provide us written authorization to use your medical information for other purposes.

YOUR RIGHTS TO PRIVACY:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Health and Human Services System, HIPAA Project Management Office. If you request a copy of information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. For more information call **(402) 471-8417.**

- **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for HHSS. To request an Amendment, your request must be made in writing and submitted at the Site of Service, or to the State of Nebraska, Health and Human Services System, HIPAA Project Management Office**.** In addition you must provide a reason which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for HHSS;
  - Is not part of the information which you would be permitted to inspect and copy; or,
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Health and Human Services System, HIPAA Project Management Office address on the top of this Notice. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list to be provided to you: for example, on paper, or by e-mail..

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not use or disclose information about a surgery you had performed.

- **We are not required to agree to your request for restrictions.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing at the Site of Service, or to the State of Nebraska, Health and Human Services System, HIPAA Project Management Office at the address on the top of this Notice. In your request you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply; for example, disclosures to your spouse.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing at the Site of Service, or to the State of Nebraska, Healthand Human Services System, HIPAA Project Management Office. Your request must specify how or where you wish to be contacted.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with **HHSS** or with the **Secretary of the U.S. Department of Health and Human Services**. To file a complaint with HHSS, you may contact our Privacy Contact, **HHSS HIPAA Project Management Office** at **(402) 471-8417** Monday through Friday from 9:00 a.m. to 4:30 p.m., except State holidays, or hhss.hipaaoffice@hhss.state.ne.us for further information about the complaint process. To file a complaint with HHS, contact: **Secretary, Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-866-OCR-PRIV (627-7748), 1-866-778-4989-TTY. You will not be penalized for filing a complaint.**

Changes to the Notice of Information Practices

The State of Nebraska Health and Human Services System reserves the right to amend this Notice at any time in the future. Until such amendment is made, HHSS is required by law to abide by the terms of this Notice. HHSS will provide notice of any material change in revision of these policies.

Contact Information

This notice fulfills the "Notice" requirements of the Health Information Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at the State of Nebraska, Health and Human Services System please direct them to: The HIPAA Project Management Office, 301 Centennial Mall South, Lincoln, Nebraska 68509-9449. By e-mail to hhss.hipaaoffice@hhss.ne.gov.

Informed Consent and Release of Medical Information

1. Read this page.
2. Keep this page for your records.

- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I understand that I must either be enrolled in Every Woman Matters (EWM) or fall within the income guidelines in order to be eligible for enrollment. I also understand that in order to take part in the NCP, I must sign below.
- If I am under 50 years of age, I know I cannot be a part of the NCP.
- I understand that the NCP will look at my health history and tell me what colon cancer screening test is best for me if I am eligible to participate.
- Based on my health history, I may recieve screening and/or health education materials.
- I know that the NCP will help cover the cost of colonoscopy if the NCP finds that it is the best type of colon cancer screening test for me or follow up after a positive Fecal Occult Blood Test (FOBT).
  - If I receive a colonoscopy through the NCP I understand that I will be asked to pay 10% of the cost or as much as I am able.
  - I understand that my payments will help others with colonoscopy costs through the NCP.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by the NCP.
- The NCP may remind me when it is time for me to go to my screening exams and send me information by mail to help me learn more about my health. I will follow through on any advice my doctor may give me.
- I understand that the NCP does not pay for treatment if diagnosed with colon cancer. NCP staff will assist me in finding the most appropriate treatment resources.
- My doctor, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal sceening, diagnostic tests, and/or treatment services to the NCP.
- I understand that the NCP may follow up with my primary care doctor if my past medical records need to be reviewed to determine the best colon cancer screening for me.
- My name, address, and/or other personal information will be used only by the NCP. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources.
- Other information may be used for studies approved by the NCP and/or The Centers for Disease Control and Prevention for use by outside researchers to learn more about colon health. These studies will not use my name or personal information.

Nebraska Health and Human Services System - Nebraska Colon Cancer Screening Program
301 Centennial Mall South, P.O. Box 94817 - Lincoln, NE 68509-4817
1-800-532-2227 - Fax: 1-402-471-0913

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services System. #U57/CCU706734-06, #U57/CCU7191-66, and #U55/CCU725047-01

For Every Woman Matters clients, 50+, ONLY

Colon Health History

Nebraska Colon Cancer Screening Program

1. **All questions must be answered. Please print.**
2. **Read and Sign the back of this page.**
3. **Return this form to the Nebraska Colon Cancer Screening Program.**

Version June 2006

First Name	Initial	**Last Name**	Maiden Name *(if applicable)*	**Date of Birth** month / day / year

How did you hear about the program?
❑Doctor ❑Other healthcare provider ❑Family ❑Friends
❑Radio ❑Television ❑Magazine ❑Newspaper ❑Billboard ❑Mailing / Flyer ❑EWM Program
❑Website ❑Community Event ❑Other _____

Family History: (please refer to page 4 for common screening terms)

How many family members (parents, brothers, sisters, children) have been told they have colon cancer or rectal cancer?
(please circle) 0 1 2 3+ Don't Know

How many of those family members with colon cancer were under the age of 60? *(please circle)*
0 1 2 3+ Don't Know

How many family members (parents, brothers, sisters, children) have been told they have polyps in the colon?
(please circle) 0 1 2 3+ Don't Know

How many of those family members with polyps were under the age of 50? *(please circle)*
0 1 2 3+ Don't Know

Personal History: (please refer to page 4 for common screening terms)

Have you ever had any of the following tests?:

Fecal Occult Blood Test (FOBT) ❑Yes ❑No ❑Don't Know Date ____/____/____
What did your doctor say about your exam? _____

Colonoscopy ❑Yes ❑No ❑Don't Know Date ____/____/____
What did your doctor say about your exam? _____

Sigmoidoscopy ❑Yes ❑No ❑Don't Know Date ____/____/____
What did your doctor say about your exam? _____

Double Contrast Barium Enema (DCBE) ❑Yes ❑No ❑Don't Know Date ____/____/____
What did your doctor say about your exam? _____

Have you ever been told by a doctor, nurse, or other health professional that you have had:

Crohns Disease ❑Yes ❑No ❑Don't Know
Familial Adenomatous Polyposis (FAP) ❑Yes ❑No ❑Don't Know
Hereditary Non Polyposis Colorectal Cancer (HNPCC) ❑Yes ❑No ❑Don't Know
Inflammatory Bowel Disease (IBD) ❑Yes ❑No ❑Don't Know
Ulcerative Colitis ❑Yes ❑No ❑Don't Know

Are you currently under a doctor's care for any of the above conditions? ❑Yes ❑No ❑Don't Know

Do you now have any bleeding from the rectum? ❑Yes ❑No ❑Don't Know
What did your doctor say about your rectal bleeding? _____

Have you ever been told that you have had polyps in the colon? ❑Yes ❑No ❑Don't Know
What type of polyps did you have? _____
How many polyps did you have? _____

Have you ever been told you have had colon or rectal cancer? ❑Yes ❑No ❑Don't Know
If yes, when were you diagnosed? ____/____/____

Please tell us who your primary doctor is: _____
Name of clinic: _____ City: _____ Phone: _____

Only ONE of the enrollment forms needs to be filled out.

Read and sign the Release of Medical Information located on the back of this page.

Informed Consent and Release of Medical Information

1. Read this page.
2. Sign it to show that you know what it means and agree to it.
3. Return this form in the postage paid envelope.

==========

- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I understand that I must either be enrolled in Every Woman Matters (EWM) or fall within the income guidelines in order to be eligible for enrollment. I also understand that in order to take part in the NCP, I must sign below.
- If I am under 50 years of age, I know I cannot be a part of the NCP.
- I understand that the NCP will look at my health history and tell me what colon cancer screening test is best for me if I am eligible to participate.
- Based on my health history, I may recieve screening and/or health education materials.
- I know that the NCP will help cover the cost of colonoscopy if the NCP finds that it is the best type of colon cancer screening test for me or follow up after a positive Fecal Occult Blood Test (FOBT).
  - If I receive a colonoscopy through the NCP I understand that I will be asked to pay 10% of the cost or as much as I am able.
  - I understand that my payments will help others with colonoscopy costs through the NCP.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by the NCP.
- The NCP may remind me when it is time for me to go to my screening exams and send me information by mail to help me learn more about my health. I will follow through on any advice my doctor may give me.
- I understand that the NCP does not pay for treatment if diagnosed with colon cancer. NCP staff will assist me in finding the most appropriate treatment resources.
- My doctor, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal sceening, diagnostic tests, and/or treatment services to the NCP.
- I understand that the NCP may follow up with my primary care doctor if my past medical records need to be reviewed to determine the best colon cancer screening for me.
- My name, address, and/or other personal information will be used only by the NCP. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources.
- Other information may be used for studies approved by the NCP and/or The Centers for Disease Control and Prevention for use by outside researchers to learn more about colon health. These studies will not use my name or personal information.

Signature	Date of Signature
Please Print Name	Date of Birth

Nebraska Health and Human Services System - Nebraska Colon Cancer Screening Program
301 Centennial Mall South, P.O. Box 94817 - Lincoln, NE 68509-4817
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❑ *I am over the age of 50 and am not enrolled in Every Woman Matters.*

Enrollment Form

Nebraska Colon Cancer Screening Program

1. **All questions must be answered. Please print.**
2. **Read and Sign the back of this page.**
3. **Return this form to the Nebraska Colon Cancer Screening Program.**

Version June 2006

First Name	Initial	**Last Name**	Maiden Name *(if applicable)*

Birthdate month / day / year	Age	Gender M / F	Social Security #

Address	**City**	County	**State**	**Zip**

Home Phone ( )

Work Phone ( )

Contact person: _____

Relationship:_____ Phone: (___)_____

Address:_____

City:_____State:_____ Zip:_____

How did you hear about the program?

❑Doctor ❑Other healthcare provider
❑Family ❑Friends ❑Radio
❑Television ❑Magazine ❑Newspaper
❑Billboard ❑Website ❑Mailing / Flyer
❑EWMProgram ❑Community Event
❑Other_____

What race or ethnicity are you?

❑American Indian Tribe _____
❑Black/African American ❑Mexican American
❑White ❑Asian
❑Pacific Islander
❑ Other _____

Are you of Hispanic/Latina/Latino origin?

❑Yes ❑No

Country of origin _____

What is your primary language?

❑English ❑Spanish
❑Vietnamese ❑Other_____

❑Highest grade in school you completed: *circle one* **0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+**

I will be required to show proof that my income is within the NCP income guidelines when I am contacted by the NCP staff. If I am found to be over the income guidelines, I will be responsible for my bills.

What is your household income before taxes?
Yearly Income: $

How many people live on this income?

Do you have:

❑Medicare Part A and B **❑Medicare Part A only**
❑Medicaid (full coverage for self) **❑None/No Coverage**
❑Private Insurance with or without Medicaid Supplement *(please list)*

_____

Is your insurance an HMO? ❑Yes ❑No

If you have Medicaid for yourself or your insurance is an HMO, you may not enroll in the Nebraska Colorectal Program.

Family History: (please refer to page 4 for common screening terms)

How many family members (parents, brothers, sisters, children) have been told they have colon cancer or rectal cancer? *(please circle)* 0 1 2 3+ Don't Know

How many of those family members with colon cancer were under the age of 60? *(please circle)*
0 1 2 3+ Don't Know

How many family members (parents, brothers, sisters, children) have been told they have polyps in the colon? *(please circle)* 0 1 2 3+ Don't Know

How many of those family members with polyps were under the age of 50? *(please circle)*
0 1 2 3+ Don't Know

Personal History: (please refer to page 4 for common screening terms)

Have you ever had any of the following tests?:

Fecal Occult Blood Test (FOBT) ❑Yes ❑No ❑Don't Know Date____/____/____
What did your doctor say about your exam? _____

Colonoscopy ❑Yes ❑No ❑Don't Know Date____/____/____
What did your doctor say about your exam? _____

Mailing Address: Nebraska Colon Cancer Screening Program -301 Centennial Mall South, P.O. Box 94817-Lincoln, NE 68509-4817

MUST COMPLETE AND SIGN BACK ☞☞☞☞

Nebraska Colon Cancer Screening Program Enrollment Form (continued)

Personal History: ***(continued)***

Sigmoidoscopy ❑Yes ❑No ❑Don't Know Date ____/____/____
What did your doctor say about your exam? _____
Double Contrast Barium Enema (DCBE) ❑Yes ❑No ❑Don't Know Date ____/____/____
What did your doctor say about your exam? _____

Have you ever been told by a doctor, nurse, or other health professional that you have had:

Crohns Disease	❑Yes	❑No	❑Don't Know
Familial Adenomatous Polyposis (FAP)	❑Yes	❑No	❑Don't Know
Hereditary Non Polyposis Colorectal Cancer (HNPCC)	❑Yes	❑No	❑Don't Know
Inflammatory Bowel Disease (IBD)	❑Yes	❑No	❑Don't Know
Ulcerative Colitis	❑Yes	❑No	❑Don't Know
Are you currently under a doctor's care for any of the above conditions?	❑Yes	❑No	❑Don't Know
Do you now have any bleeding from the rectum?	❑Yes	❑No	❑Don't Know

What did your doctor say about your rectal bleeding? _____

Have you ever been told that you have had polyps in the colon? ❑Yes ❑No ❑Don't Know
What type of polyps did you have? _____
How many polyps did you have? _____

Have you ever been told you have had colon or rectal cancer? ❑Yes ❑No ❑Don't Know
If yes, when were you diagnosed? _____/_____/_____

Please tell us who your primary doctor is: _____
Name of clinic: _____ City: _____ Phone: _____

Informed Consent and Release of Medical Information

- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I understand that I must either be enrolled in Every Woman Matters (EWM) or fall within the income guidelines in order to be eligible for enrollment. I also understand that in order to take part in the NCP, I must sign below.
- If I am under 50 years of age, I know I cannot be a part of the NCP.
- I understand that the NCP will look at my health history and tell me what colon cancer screening test is best for me if I am eligible to participate.
- Based on my health history, I may recieve screening and/or health education materials.
- I know that the NCP will help cover the cost of colonoscopy if the NCP finds that it is the best type of colon cancer screening test for me or follow up after a positive Fecal Occult Blood Test (FOBT).
  - If I receive a colonoscopy through the NCP I understand that I will be asked to pay 10% of the cost or as much as I am able.
  - I understand that my payments will help others with colonoscopy costs through the NCP.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by the NCP.
- The NCP may remind me when it is time for me to go to my screening exams and send me information by mail to help me learn more about my health. I will follow through on any advice my doctor may give me.
- I understand that the NCP does not pay for treatment if diagnosed with colon cancer. NCP staff will assist me in finding the most appropriate treatment resources.
- My doctor, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal sceening, diagnostic tests, and/or treatment services to the NCP.
- I understand that the NCP may follow up with my primary care doctor if my past medical records need to be reviewed to determine the best colon cancer screening for me.
- My name, address, and/or other personal information will be used only by the NCP. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources.
- Other information may be used for studies approved by the NCP and/or The Centers for Disease Control and Prevention for use by outside researchers to learn more about colon health. These studies will not use my name or personal information.

Signature Date of Signature

 Please Print Name Date of Birth